

Name: (Print Clearly): _____ Date of Birth: ____/____/____

PATIENT FINANCIAL POLICY:

Our Dermatology practice is structured as a traditional full payment due at time of service. We accept payment in the form of cash, debit, check or any credit card. Dr. Slater is enrolled as a nonparticipating provider in Medicare but is not a member of any private insurance network or managed care plan. You will be provided with a detailed coded invoice which you may forward to your insurance company, keeping a form for your records (except for Medicare which will be filed directly from our office and then Medicare will reimburse directly to your home).

Depending on the type of plan you have, you may be reimbursed only a percentage of the money you paid. Certain types of plans reimburse differently or not at all for services from a physician that is not part of the plan or network. If you have any questions about how your insurance plan operates you should check with your insurance company.

Depending on the complexity of your skin problem, typical charges for a new patient visit range from \$98-\$146 and follow-up visits from \$58-\$93. A biopsy charge is usually \$126 and cryosurgery usually begins at \$97. Charges for Medicare patients are different and follow the Medicare limited fee schedule.

Please sign below if you understand the financial responsibilities of your visit and if you understand that your insurance company may not reimburse the charges.

Signature of Patient or Responsible Party _____ Date: ____/____/____

Please present insurance cards and photo ID to the receptionist so copies may be made in case biopsies or labs are sent.

NOTICE OF PRIVACY PRACTICES (HIPAA COMPLIANCE)

I am informed of Dr. Slater's Notice of Privacy Practices (HIPAA compliance) as detailed in the waiting room notebook. I know I have the right to restrict how protected health information about me is used or disclosed.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Signature of Patient or Responsible Party _____ Date: ____/____/____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself.

Signature as it appears on Medicare Card: _____ Date: ____/____/____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP Card: _____ Date: ____/____/____